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TECHNICAL PERSONNEL IN MENTAL HEALTH, PROCEEDINGS OF THE 1966 SUMMER STAFF TRAINING INSTITUTE.

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NATIONAL ASSN. FOR MENTAL HEALTH, NEW YORK, N.Y.

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AN INSTITUTE WAS HELD FOR PROFESSIONAL STAFF MEMBERS OF MENTAL HEALTH ASSOCIATIONS TO CAREFULLY EXAMINE THE NEED FOR AND THE ROLE OF TECHNICAL OR SUBPROFESSIONAL MANPOWER. THIS REPORT INCLUDES SUMMARIES OF THE ADDRESSES PRESENTED TO THE PLENARY SESSIONS, SUMMARIES OF THE DISCUSSIONS AND CONCLUSIONS OF THE SEMINAR SESSIONS, AND THE RECOMMENDATIONS FOR IMPLEMENTING THE TRAINING AND EMPLOYMENT OF TECHNICAL PERSONNEL THAT WERE SUBMITTED FOR THE CONSIDERATION OF THE MENTAL HEALTH ASSOCIATION STAFF COUNCIL, THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, AND THE RESPECTIVE STATE DIVISIONS OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH. AN EVALUATION OF THE INSTITUTE INDICATED IT HAD PROVIDED CONSIDERABLE STIMULATION TOWARD AN INCREASE IN THE USE OF SPECIFIC EFFORTS DIRECTED TO THE USE OF ALL AVAILABLE SOURCES OF MANPOWER NOW IN EXISTENCE AND YET TO BE ESTABLISHED. (AL)

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10 Columbus Circle

New York, N. Y. 10019

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An institute for professional staff of mental health associations, held at the Williamsburg Conference Center, Williamsburg, Virginia, July 11-15, 1966.

Under the sponsorship of the Mental Health Association Staff Council and the National Association for Mental Health.

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FOREWORD

The Institute (and the Proceedings resulting from it) was designed to promote informed consideration and action by citizens engaged in the currently expanding battle against mental illness. The Institute took a large piece of the problem, manpower, and broke it down to look primarily at a part of it — technical or "sub-professional" manpower.

The planning groups for the Institute were convinced that Mental Health Associations must increasingly include in their programs of education and action specific efforts directed to the utilization of all available sources of manpower in the hospitals, community centers and community programs now in existence and yet to be established.

The Institute evaluation indicated considerable stimulation in this direction. The publishing of the proceedings is intended to reinforce and expand the usefulness of presentations and discussions held in Williamsburg.

Thanks are due a number of people, including the planning committee for the Institute:

Charles Feike, formerly Executive Director
Oregon Mental Health Association

Elaine Michelson, Executive Director
Metropolitan Baltimore Association for Mental Health

Mabel Palmer, Director of Special Services
Louisiana Association for Mental Health

Mrs. Dorothy Powell, Executive Director
Nassau County Mental Health Association

W. Ben Mosley, Executive Director
Georgia Association for Mental Health

Mrs. Esther Mallach, Executive Director
Westchester County Mental Health Association

Mrs. Vera G. Bruhn, Executive Director
Jefferson County Association for Mental Health

Mrs. Barbara Luther, Executive Director
District of Columbia Mental Health Association

Mr. Bernard Yabroff, Director, and the staff of the Employment Opportunities Branch, Division of Adult Vocational Research, U. S. Office of Education, were of notable assistance in the planning process.

Special mention should also be made of the work of Dr. Max Silverstein, then Executive Director of Pennsylvania Mental Health, Inc., and now Lecturer in Community Organization, University of Pennsylvania School of Social Work, who acted as Planning Committee Chairman; and Raymond Glasscote, Chief, Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, who was Program Chairman. Dr. Elaine Cumming, in addition to her other roles as faculty and conference evaluator, wrote the Institute summaries which comprise the Proceedings.

Mrs. Jane Thomas, Assistant to the Director of Program Services, served as the National office representative; Edd T. Hitt, Executive Director, Virginia Association for Mental Health, and Mental Health Association Staff Council Treasurer, was Host Association Director; Robert C. Vandivier, then Regional Director and currently Executive Director, Pennsylvania Mental Health, Inc., was Institute Coordinator; Miss Margaret Margrave, Field Representative with the National Association for Mental Health, Inc., handled the social events.

Mrs. Winthrop Rockefeller, then President of the National Association for Mental Health, and a member of the Board of Directors of Colonial Williamsburg, assisted the planners, faculty and participants in many ways, and contributed significantly to the success of the Institute.

BRIAN O'CONNELL, *Executive Director*
The National Association for Mental Health, Inc.

RICHARD C. HUNTER, *President*
Mental Health Association Staff Council, and Executive Director, Mental Health Association of Southeastern Pennsylvania

December 1966

SUMMARIES OF ADDRESSES TO THE PLENARY SESSIONS

WHY WE'RE HERE — Donald Kenefick, M.D.*

Dr. Donald Kenefick opened the Institute with a keynote statement of the mental health manpower problem. He made three major points: first, there is an absolute shortage of all kinds of manpower, but the gravest is the lack of personnel with a level of skill between the highly trained professional and the in-service trained technician; second, there is an improper use of highly trained staff who are reaching only a fraction of the patients while they could be influencing many more if they would assume managerial roles; and third, the part-time worker and the poor are two major untapped sources of manpower.

Elaborating on these points, Dr. Kenefick said that mental health manpower is inadequate at literally all levels from doctors to secretaries, and that ending the shortage will require revolutionary new approaches. New skills must be added to all existing disciplines at the same time that new "sub-professions" are being developed; staff that is already trained must be re-trained and redeployed, and the untrained must be trained.

Dr. Kenefick thought that the Mental Health Associations of the country could play several roles in such a manpower revolution. They could be active in:

1. Setting standards in the sense of conveying the values of the nation to governments and professionals,
2. gathering information,
3. developing propaganda regarding what is good and bad in the present system, and particularly, what needs to be done,
4. pressing for adequate salaries as well as for good working conditions for mental health personnel, and,
5. formulating new and reforming old legislation so as to facilitate new patterns of manpower training and utilization.

Dr. Kenefick warned that the development of a new echelon of sub-professional workers, and the training required for such develop-

*Professional and Research Director, National Association for Mental Health.

ment could be expected to impinge on the investment in the *status quo* of the traditional professions. Consequently, clarification of the relationships among professionals will be needed so as to maximize the skills of every group. The relationship of new types of mental health workers to existing professionals cannot be worked out, however, until such professionals are willing to give up some of their traditional activities. In general, Dr. Kenefick predicted that professionals would have to take over what he called managerial roles and delegate practitioner roles to sub-professionals, because practitioners act in one-to-one situations, while managers reach whole populations. There is need for retraining all professionals in the kinds of managerial skills used by public health officials, even though it is painful for clinicians to give up the one-to-one relationship with patients.

Dr. Kenefick made one very special plea to the group asking them to try to face realistically the difficult problems involved in utilizing poor people and especially negroes as equal members of therapeutic teams. What is required of us, he declared, in concluding, is guts, sensitivity and insight into our own need to be superior to someone.

A PROFILE OF TECHNICAL PERSONNEL —

Raymond Balester, Ph.D.*

Dr. Balester spoke on the problem of recruiting and training technical and non-professional personnel in the mental health field. He pointed out that today's emphasis on community care has exaggerated an already acute manpower problem, and that few technical schools and community colleges are at present prepared for this increased demand. He cited as an example, the 36 per cent increase in agricultural vocational training that has accompanied a decrease of about the same magnitude in the demand for this kind of work. Fortunately, he said, educational institutions are just now beginning to experiment with new training patterns at many levels, but there is little leadership from the mental health field. The question Dr. Balester put to the delegation was, will the Mental Health Associations of the country supply the leadership needed for the mental health manpower revolution? Can these associations reformulate their goals sufficiently to help in the development of a pool of non-professional manpower to alleviate the shortage?

Dr. Balester pointed out that the gravity of the manpower shortage can be seen best in terms of the population increase that lies

*Chief, Experimental and Special Training Branch, National Institute of Mental Health.

ahead and the increased demand for services that it will bring. The United States Surgeon General's Office estimates, for example, that at the present rate of increase there will be a need for 3.2 million professional and non-professional persons in health services within the next decade.

Dr. Balester defined non-professional manpower as staff characterized by no formal preparation or professional training. The technical training that they receive is designed to prepare them specifically for entering the mental health field. Until a way is found of making use of more such technicians, he said, there will be unfilled jobs in treatment facilities, long waiting lists, inadequately trained personnel and inadequate research efforts.

Concern about manpower shortages is at present almost entirely confined to the professions that are trying to meet the public's need. There is considerably less expression of concern for the public itself. Professionals in fields related to mental health, such as judges, teachers, and welfare workers are in some instances recognizing their own role in the mental health field and looking for appropriate auxilliary training. These people have, however, recognized the need themselves and have used government funding to train themselves. Non-professional groups, in contrast, are not similarly motivated; any movement of them into mental health work must be stimulated from the outside, for example, by educational and recruitment programs initiated by Mental Health Associations.

Dr. Balester asked the group to consider why it is that at this time there is such a need for new manpower. He suggested four reasons:

1. Mental health is increasingly being recognized as over-determined, and therefore needing the support of many community resources if it is to be maximized,
2. the development of the Community Mental Health Center concept with its underlying idea of less disruption of the life of the patient has generated a need for a pool of versatile manpower to work in the family and with other community agents,
3. changes in public educational philosophy have led to the development of programs for training staff from whatever level they happen to be at, to more sophisticated skills, and,
4. changes in the economic scene have caused a shift away from agriculture and manufacturing, which require little training, toward service trades, which require more training. There is still a

need for more "pre-entry" training for people leaving manufacturing and joining human services.

Dr. Balester recommended that the delegation use the booklet, *The Indigenous Non-Professional* as a source of information on the kinds of technical jobs needed in the mental health field, and he briefly discussed some examples:

1. The University of Pittsburgh Medical School, Department of Child Psychiatry, sponsors a program to train child care workers, which includes both a two-year post-high school training program and a Master's degree program.
2. Purdue University has developed a two-year extension program of the Community College type to train mental health workers. Graduates of this program are qualified for many jobs, but they can also proceed to higher training, so that the program is, in part, a recruiting device for the professions. There is a great need, according to Dr. Balester, to develop more of these programs in technical and vocational training schools, as very few exist now.
3. Casework aides are usually trained in on-the-job apprenticeships, and, although such training is easy to promote, funding the students while giving them training is a major problem.
4. The largest group of non-professional mental health personnel in the country is psychiatric aides; some 96,000 are employed at present. Six out of ten of them are women. One half have completed high school. One out of ten has completed from one to three years of college, and one per cent, four or more years of college. The median education of psychiatric aides is 11 years, as compared with ten years in the general population. The median salary for this job is $3,500, ranging from $1,000 to $5,000. Psychiatric aides have a 30 per cent staff turnover every year, but there is evidence that the rate decreases when hospitals become less centered on custody and more on therapeutic intervention. The National Institute of Mental Health Survey of psychiatric aides revealed that while the work most enjoyed by psychiatric aides is counseling, there is little pre-service training for this task, and the majority want more training.
5. "Socio-environmental therapist" is the name given to graduates of a program of training for college graduates at Philadelphia State Hospital. These therapists are trained for rehabilitative work with groups of chronic patients. There is some thought of trying to train high school graduates for this important role.

6. A new two-year pilot program of training occupational and recreational aides has been based on an appreciation of the therapeutic value of games in the treatment of various kinds of illness.
7. Women are trained as child development counselors to help the professional staffs at well-baby clinics.
8. A project in Nashville trains senior citizens as recreational and group leaders. It has branched out into sponsoring such things as tutorials and Godparent programs.
9. Citizens Advice Agencies, such as were originally developed in England during the war to perform a sort of switchboard function in the social service field, have recently been developed using in-service trained staffs.

Dr. Balester described three main untapped pools from which such technical manpower can be drawn:

1. Of the 87,000,000 people who will be working full time by 1970, if present projections are accurate, 26,000,000 will be young people just starting in the labor force.
2. Three million women are expected to switch from housework to jobs, and,
3. 17,000,000 of the 20,000,000 persons over 65 will be voluntarily or involuntarily retired.

Among the young people who will enter the labor force are 3,800,000 who turned 18 this year; of these, three out of ten are school drop-outs. Twenty-five per cent of these school drop-outs cannot find employment. Nine out of ten of them have no occupational training. Stronger vocational guidance as well as post-high-school training is indicated, if this vital resource is not to be wasted.

Four out of every ten students continue their education beyond high school; two out of the ten will finish college. Much greater effort is needed to encourage these young people to take training in the mental health fields.

Women comprise 30 per cent of the total labor force, and 50 per cent of all women between 18 and 20 years of age are at work. The percentage then falls off, but it reaches 50 per cent again between 45 and 55 years of age. This latter group are candidates for retraining for mental health jobs.

Eighty-five per cent of senior citizens have incomes of less than $3,000 a year; they are an obvious untapped source of both part-time and full-time work.

In conclusion, Dr. Balester said that the time is ripe to make major changes in the manpower picture; the need is great, the labor pool is there, and educational institutions are on the verge of change. If the mental health field is to take advantage of this fortunate combination of circumstances, it must provide the leadership and provide it at once.

NEW FRONTIERS IN TRAINING — Harold McPheeters, M.D.*

Dr. Balester had described the pools from which new manpower could be drawn and the kinds of jobs they could be drawn into. Dr. McPheeters described the role of the Community Colleges in the development of mental health workers. He began by recalling Albee's prophetic 1959 review of the manpower problem, and pointed out that until then most people had assumed that if salaries were high enough, psychiatrists, psychologists, nurses and social workers could be recruited. Albee made it quite plain that there simply was never going to be enough professional manpower to go around in the foreseeable future. He did suggest, however, that one solution to the mental health manpower shortage was the development of some kind of worker at less than the traditional level of professional training. In the years since 1959, Albee's suggestion has lain quiescent, and, until recently, little action toward implementing it has taken place.

The community college, or junior college, in Dr. McPheeter's opinion, is the most vigorous and promising development in the recent history of higher education. Most of the community colleges have four major offerings:

1. Short-term continuing education courses,
2. courses leading to certification in some technical specialty,
3. standard college courses that may be taken for transfer credit at a four-year college or university, and,
4. associate degree programs in specialties such as nursing, which lead to registration as a qualified professional.

The community colleges have been more flexible and creative in setting up training programs to meet locally defined needs than the regular colleges, where the stress is on academic achievement for its own sake. The community colleges are, for example, rapidly taking over nursing training from the hospital-based diploma schools of nursing. These nursing programs concentrate training into a two-year period and award an Associate of Arts degree. The graduates are then

*Associate Director for Mental Health Training and Research, Southern Regional Education Board.

eligible to take examinations and become registered nurses. These graduates, are, moreover, not merely technicians; they are associated professionals, capable of all kinds of ordinary clinical judgment and activity; they are expected to be practitioners but not teachers, researchers, or administrators.

The Southern Regional Educational Board has recently explored the possibility of training mental health workers at community colleges. An associated professional person who will be a practitioner working under the over-all direction of fully qualified professionals is under consideration. The training envisioned is a real clinical education. Dr. McPheeters emphasized that education for practitioners must have a status in its own right, and its graduates should not be the cast-offs from the race to become professors, researchers or administrators. He expected that people trained as practitioners in these programs would be almost exclusively salaried employees of public agencies, perhaps working in teams under professional-managerial supervision. He expected to see them in a variety of institutions, such as mental hospitals, schools for the retarded, children's programs, and especially in community programs. The basic preparation for these practitioners would be in how to work with people; they would be taught mental health principles and something about mental disorders and their treatment and rehabilitation. Students in such training programs could have options in both course and field work that would lead to a semi-specialization in such an area as psychology, social work, rehabilitation or children's work, but specialization would not be the goal of the program. Graduates would need some further in-service training in their agencies and their initial service would be closely supervised.

Such an approach to training would be more likely to result in the recruitment of indigenous workers from the community, Dr. McPheeters thought, because the majority of community college students come from within 50 miles of the school. Graduates could therefore be expected to be more geographically stable than full professionals, who tend to be very mobile, and therefore, such a program would help to keep mental health workers in the areas in which they were trained.

Dr. McPheeters warned that a program such as he described would have problems, but he believed these could be foreseen and perhaps circumvented, partly through capitalizing on the experience of the associate nursing degree programs. He identified the most important problem as inventing the new profession itself. This would

entail defining job duties, writing job descriptions, establishing positions and salaries, setting up curricula, developing techniques for recruitment, and finally, moving toward licensure. The community colleges cannot be expected to do this task on their own. Their traditional pattern is to respond to community demands rather than to stimulate them, and, as there are no job openings for mental health workers, it is unlikely that programs will be developed unless the mental health professions take an interest in planning them.

Another major problem is vagueness about the use of the new workers, according to Dr. McPheeters. He illustrated his point by describing the answers to questionnaires sent to the mental health commissioners in 15 Southern states. Asked if they would hire people with junior college training, all these administrators had reservations about what the job duties would be, how they would fit into the present structure, and how many of them could be absorbed into the present plans.

Like the other speakers, Dr. McPheeters saw a serious problem in the negativism of the mental health professionals, who are uncertain about what a new type of associated professional will do to their own status.

In spite of these problems, Dr. McPheeters felt that there is no intrinsic reason why there should not be a rational development of this new professional calling in the next ten years. He felt that one way to expedite development was to start the new programs on a regional basis because more than one state or institution is needed so that the job descriptions will have general currency and the graduates will have recognition. The professionals will also have less chance to protest a regional plan than they would an isolated program, and the colleges would find it easier to develop curriculum for a range of agencies than for a single one which would tend to over-specialize the students. Finally, a regional basis would mean that the programs would have enough in common that the jobs could be transferrable and the colleges would be able to share experiences.

Dr. McPheeters further proposed a pilot project involving only a few states and designed for the following purposes:

1. To decide what kinds of program activities are necessary to meet various mental health needs,
2. to evaluate which of the duties should be done by a person with a community college level of training,
3. to bring mental health professionals and personnel specialists together with community college people,

4. to write some sample job descriptions based on the studies done,
5. to develop staff to meet with commissioners, superintendents, and others both to explain the job descriptions and to get commitments that positions for mental health workers would be established and funded at appropriate salary levels; and in appropriate administrative structures,
6. to assist community colleges in applying for training grants, in recruiting staff, and in planning facilities,
7. to assist in recruitment by giving publicity to the mental health worker idea and preparing,
8. to provide a forum for the various persons developing this new associate profession, and,
9. to provide information for other jurisdictions.

Dr. McPheeters finally proposed that, that while he may have sounded as though these activities would necessarily have to run in the sequence he had named, there would be no need to maintain a rigid separation among them. Certain areas of need, job duties, and so on, could be identified early, job descriptions set up, and training begun for those areas, while other areas were still being identified. In this way, the early curricula could be modified by later evaluations and new developments.

In summary, Dr. McPheeters suggested that the community colleges are ready to undertake the training of the new kind of associate professional when the leadership comes from the mental health professions and the Mental Health Associations.

CASES OF EFFECTIVE UTILIZATION OF TECHNICAL PERSONNEL IN MENTAL HEALTH PERSONNEL — John Cumming, M.D.*

Dr. John Cumming offered a change of pace by describing some examples, from his own experience, of the use of non-professionals in the treatment of the mentally ill. Although his examples were mostly taken from experiences with psychiatric aides, he proposed that the mental health worker could be used for an even wider range of functions. Like Dr. Balester, he dismissed the idea that there was something new about the indigenous non-professional, who was, in his opinion, only an untrained person living near his work. Mental hospitals have been staffing their wards with such people for years. Furthermore, in-service training programs for attendants had been well established by the 1940's, although remotivation techniques have

*Deputy Commissioner, New York State Department of Mental Health.

only recently been taught to non-professionals in order that they can take part on treatment teams.

Dr. Cumming gave examples of therapeutic activities carried out by two kinds of non-professionals, patients themselves, and psychiatric aides.

1. Patients as therapists:
   a. In one hospital it was discovered that when chronic schizophrenics were asked to spoonfeed helpless patients during a staff shortage, this maneuver led to the improvement of the schizophrenics as well as the aged patients.
   b. It has been found that if the patients give a Christmas party for the staff, the initiative required leads to more therapeutic results than if they are given a party by the staff, and uses less staff time.
   c. In one hospital, police were brought directly into the wards for training in the handling of mentally-ill persons, and worked there as attendants on a temporary basis under the guidance of both patients and psychiatric aides.
   d. Mentally retarded girls have been used as nursemaids for autistic children, whom they appear to tolerate more readily than normal people do.
   e. Patients have been used as guides and receptionists in hospitals, thus developing confidence while relieving the staff for other duties.
   f. Patient government has been useful therapeutically, but its limits must be clear and the patients must be allowed to make mistakes. It perhaps should not be counted as saving staff time.

2. Psychiatric aides as therapists:
   There are a few situations, where highly trained aides and attendants are virtually indistinguishable from other staff, a situation that can demoralize the highly trained professional. At the other extreme, and much more commonly, is the rigidly-defined and limited job assignment that leads to the demoralization of the non-professional. In between these two extremes is the flexible and creative use of non-professionals in specific areas based on their talents and qualifications. Some examples are:
   a. The use of psychiatric aides as clinical administrators. In the day-to-day running of hospital wards, it is important for authority to be genuinely distributed so that the technical staff do not have to "ask the doctor" about every decision,

b. Non-professionals were trained in one hospital to take psychiatric histories. Although there are risks in such a process of missing organic clues, it must be remembered that physicians can miss social clues through unfamiliarity with the culture of the patient, the hospital ward, and the informal patient community itself.
c. Some psychiatric aides have acted as consultants in architectural planning; they are so thoroughly conversant with the job to be done that their advice on specific details is invaluable.
d. The aide's knowledge of the local community is useful in finding foster homes for patients, or arranging job placements.
e. Group therapy can involve non-professionals who are often particularly sensitive to patients' meanings, but it has not been uniformly successful because tolerance of unconscious material seems to require considerable theoretical training. Activity groups are on the whole a more useful utilization of non-professional talent, and probably contribute more to the patients' welfare.
f. Aides can be used as teachers of new attendants; in fact, they should be brought into community college programs for mental health workers, because, if training is not related to the actual institutional situation, there is always a danger that it will be undermined by ward staff who resent the intrusion of new ideas.
g. Attendants have been used as practitioners with individual patients. One attendant, for example, was able to retrain, under professional supervision, a man suffering from Korsokoff's Syndrome. Such a use of technical personnel spares professional time for other matters.

It will be increasingly important, according to Dr. Cumming, to influence training in the mental health field in the direction of real service needs. Courses in psychology can be considerably less useful when they are not attached to practical and therapeutically-oriented training. An important ingredient often missing from college courses is the ability to communicate with the patients while not patronizing them.

Finally, it is imperative that the institutions seeking to utilize non-professional personnel in a creative way, have what can be called a freedom-producing administrative structure; that is, one which delegates sufficient authority to them to allow the scope necessary to realize its therapeutic talent.

REMARKS FROM THE PRESIDENT — Mrs. Winthrop Rockefeller

Mrs. Winthrop Rockefeller, addressing a luncheon meeting, brought greetings as President of the National Association for Mental Health from the Association's Board of Directors, and then, as a retiring president, added some farewell observations of her own.

Mrs. Rockefeller did not address herself directly to the manpower problem, but concentrated on some of the more general problems facing the mental health movement. She began by saying that the most significant factor for success in any mental health association is a competent, skilled executive director. Chapters and affiliates that have progressed, grown and prospered, have almost invariably had an able, knowledgeable staff person on the job. Such an executive understands both what to do and what not to do in his role as motivator, guide, administrator, coordinator and interpreter of the Board's policy. One of the marks of a good executive is that he constantly thinks about where the chapters should be in five years time. Too many executive directors, according to Mrs. Rockefeller, fail to crystallize in their own minds a definite plan for progress.

Mrs. Rockefeller suggested an analogy to help clarify her conception of the kind of person the staff executive should be. She pointed out that pearls are made by oysters, not because the oyster is a creative artist, but because a grain of sand gets into its shell and makes it uncomfortable. Not all oysters produce pearls, however; some are lucky enough to keep the sand out and to live placid, routine, contented lives until they are eaten. The outstanding executive director is like the oyster; he performs best when somewhat irritated, when challenged and stimulated. The grain of sand is the desire for progress, the annoyance with things as they are, the determination to succeed. The pearl produced is many such things as: developing genuinely effective community service programs, guiding the chapter toward fiscal responsibility and adequate operating capital, identifying the organization as a progressive and vital instrument for service in the community, and, most important of all, improving service on behalf of the ultimate beneficiary, the mental patient and his family.

Mrs. Rockefeller continued her point by saying that there is even more need for dedication and hard work than surface evaluation indicates. She pointed out that the mental health movement is the most underfinanced organization of all the so-called major health agencies. Furthermore, it is not only ineffectual at raising money, but also at many other vital things, for example, in reporting. Of the

approximately 900 affiliated chapters across the country, only 269 filled out national inventory reports in 1964, and in 1965 still only 351 of the affiliates were willing to take time to provide this important information on their programs. Using the results from these inventories, Mrs. Rockefeller pointed out some of the ways in which the movement had fallen short, using as an example the efforts made in 1964 regarding public education and information.

In 1964, 252 of the 269 chapters reporting indicated that they sponsored lectures, courses, seminars and other programs for the general public. In 1965, with more chapters reporting the number had fallen to 210. Only 139 affiliates published newsletters; only 91 sponsored tours to mental health facilities other than state hospitals. Of 351 chapters reporting last year, only 107 took advantage of radio and television facilities. Only 151 chapters used spot announcements on radio and television through the year, and only 177 used spot announcements during mental health week or fund raising campaigns. Only 53 chapters in the whole country placed 24 sheet highway billboards; only 15 placed mental health placards on trains, buses and depots; only 94 placed mental health window cards in stores, banks and commercial buildings; only 249 reported that they placed news releases concerning their activities with local newspapers. According to Mrs. Rockefeller, such activities as presenting public programs, making mental health literature available, sponsoring tourists to mental health facilities and other public education activities should be the cornerstone of all associations. Nevertheless, in no public education and information activity are 100 per cent even of the reporting chapters taking an active part. In fact, in many public education areas less than half the chapters are doing so.

Mrs. Rockefeller concluded that too many chapter executives were resting in comfortable, sand-free oyster beds, and she ended her speech by hoping that the chapters would give their fullest cooperation to their new executive director, Mr. Brian O'Connell, in the interest of improving this situation.

BARRIERS TO BE OVERCOME — 1. — Mr. H. M. Forstenzer*

Returning to the manpower problem, Mr. Forstenzer talked about some of the practical obstacles in the path of developing and utilizing a new echelon of mental health workers. He pointed out that resistance to change is widespread, and that it becomes institutionalized not only in state hospitals but also in clinics and even in mental

*Deputy Commissioner, New York State Department of Mental Hygiene.

health associations — perhaps most of all in the latter. Although resistance has to be overcome, and change must be brought about, change *qua* change is not enough. All changes must be intelligent, planned and orderly.

The first major barrier to change that Mr. Forstenzer saw was in the Mental Health Associations themselves. We are not genuinely filling our role as the primary representative of the consumer, he said, and this we must do if we are to take the intense interest in the development of adequate manpower that is necessary to get the job done. The Mental Health Associations will have to change their patterns of activity radically, if that is necessary in order to do this first-priority job.

The second major barrier Mr. Forstenzer recognized was the resistance of professional organizations, which have always been particularly reluctant to change. For example, in New York City, the major opposition to nurses' aide training programs came from the nurses organizations; any attempt to develop mental health workers that will place them in the same line of authority with nurses, social workers, and physicians, can expect to meet exactly this kind of resistance.

Picking up Dr. Kenefick's distinction between the managerial and practitioner roles of the professional, Mr. Forstenzer pointed out that there are not enough professionals to fill even the managerial roles let alone to take on practitioner activities, and for this reason new echelons of staff are imperatively needed. Professional resistance to utilizing such staffs are just as profound as resistance to training them, however. Such an operating principle as "nobody can supervise a social worker but a social worker," effectively ties up both the manager and the practitioner in essentially the same task.

For some reason, the professional always seems apprehensive about his role when some new worker is suggested, but it has been found that there are always more complex problems for him to solve once he is freed from the simpler ones that he is doing at present. In the course of developing new tasks there are very real problems of "role-blurring," however. Mr. Forstenzer gave the example of the Fort Logan Mental Health Center, where a team approach to therapy is used. The psychiatrists on these teams used to leave the service because they felt they had no special role and did not contribute anything that the rest could not do. Adjustments of the distribution of authority and division of labor in the teams seem to be clearing up this problem, but it has not been easy. Mr. Forstenzer warned that

there are intrinsic overlaps among the various mental health professional roles, and therefore role-blurring is an on-going problem to be solved.

A third kind of barrier lies in the paraphanalia of the merit system as we now know it in the civil service. Methods of allocating pay, tasks, and various work and rewards under the present merit system are "as outmoded as the child guidance team," said Mr. Forstenzer. New approaches to promotion and reward will have to be worked out if we are not to stifle both initiative and innovation.

A fourth group of barriers stand in the way of adequate training. A special problem is the unrelatedness of academic training to job realities. Mental health workers should be trained in service agencies whenever the job is specific enough to be learned in the service situation. When the job is not so specific, it can be learned in institutions of learning in cooperation with service agencies. The optimal place for training the new echelon of technical personnel must be carefully assessed, because although the community college appears to be the most reasonable locus, it will be necessary to include both in-service training and relevant theoretical courses in all programs.

A serious barrier to adequate educational programs is the funding of people while they are being trained. Neither training grants nor support to people who wish to upgrade their present training are in adequate supply. Finally, Mr. Forstenzer described a barrier that must be overcome before training can proceed at all, and that is the lack of preparedness of the candidates. He described a New York State experiment in which hospitals have organized a 13 week training program for school drop-outs, but have had to contract with other departments for initial training in order to bring the candidates' competence in reading and writing up to an acceptable minimum.

In spite of all of the formidable barriers of professional exclusiveness, rigidity of job structure, and the difficult problems of education itself, Mr. Forstenzer felt that it was possible to make a place for a new army of sub-professionals.

BARRIERS TO BE OVERCOME — 2. — Betram S. Brown, M.D.*

Dr. Brown addressed the conference twice. In his first talk he confirmed the previous speakers' points about professional rigidity, pointing out that a two-year dental hygienist training program had recently been abandoned because of opposition from the national professional organization. He went on to say that technical personnel

*Deputy Director, National Institute of Mental Health.

will be developed in the future in spite of all such opposition, because one-third of all federal staffing money is for technical personnel and can be used as support in service training, educational leave, and many other less routine things, for example, for hiring a trainer for a year and bringing him into a system as a consultant. Creativity and ingenuity must be exercised in order to improve the quality of technical staff, and federal money can be had to support these efforts, but it is not automatic that this will happen. One important task is to invent better uses for our resources. One example of an imaginative use of resources cited by Dr. Brown is the National Institute of Mental Health's cultural exchange program to U.S.S.R. mental hospitals. In that country there is a high staff-to-patient ratio, which of course means low unemployment in the area as well as good patient care in the hospital. Much of the unemployment created by automation in this country could be alleviated by moving people into such human service jobs, at the same time upgrading skills and upgrading the service, as the Russians have done, according to Dr. Brown.

One way to achieve imaginative use of resources is to develop enlightened consumers who push for changes. Among the changes most vitally needed are conceptual innovations about health care; for example, the concept that the individual has a "right" to see his psychiatrist is probably outmoded and should be replaced by a concept of the right of society to demand adequate treatment for all.

Many of our current concepts are rooted in the middle class, and will have to change before we can move ahead, according to Dr. Brown. The Mental Health Association's own concepts are involved here, he said, because we are all middle class to the core. This is one reason why we cannot train the poor, he added, and why we resist even talking about the one-third of the nation who are poor. More programs must be developed with and for the poor if we are to have adequate human services and a well-trained labor force.

Dr. Brown elaborated Mr. Forstenzer's point about the many administrative barriers that will have to be overcome before new mental health professionals can be introduced. He agreed that among the worst, are civil service regulations. There are, furthermore, jurisdictional disputes over what is a proper area for federal legislation, who is to train the people, and where the buck can be passed, and to whom. All lines of authority, communication and responsibility will have to be cleared up before new ideas can be put to work, he said.

Universities will also have to change, said Dr. Brown, because

they resist developing the kinds of training that society desperately needs. This problem is not limited to mental health but cuts across all fields of service. Consumer groups such as mental health associations, will have to influence universities to take on additional training responsibilities if the needed manpower is to be developed.

Finally, Dr. Brown pointed out that there is an identity issue for Mental Health Associations, who have in the past been oriented toward mobilizing volunteer services. Volunteers, he said, are quite different from technical personnel and cannot replace them, and the urgent modern need is not for more volunteers, but for a great new force of trained people. Dr. Brown appealed to the delegates to represent the consumers of these services in the establishment of a better professional work force in the future.

FEDERAL, STATE AND LOCAL RELATIONSHIPS IN DEVELOPING MENTAL HEALTH PERSONNEL — 1. — Elaine Cumming, Ph.D.*

Dr. Cumming talked about the resistance of some groups of citizens to accepting federal grants for improvement of services. Objections to the use of such funds are likely to be threefold. First, money from the Federal Government is thought to be an excessive drain on the taxpayer; second, grants-in-aid are often thought to be a new and uniquely dangerous activity of the Federal Government, and third, the legitimacy of federal intervention in local affairs is questioned.

That federal money is in some way more costly to the taxpayer than local money, is usually untrue. Federal grants are only money collected from taxpayers and redistributed to local communities. Although redistribution does cost something, all money costs something to handle, even money given by local individuals or businesses. These latter deduct their contributions from their incomes or profits, thus reducing the amount of money available in taxes, and perhaps pass on the cost to the price of goods or services. Finally, although much has been made of the cost of federal bureaucracy, considering the amount of money it handles, it probably does not cost as much dollar for dollar as such local concerns as the United Councils, whom nobody criticizes as extravagant. Federal money is, in short, about as cheap or as expensive as any other kind of money.

The idea that the Federal Government is blazing new trails when it finances local efforts is unfounded. Although contributions to health and welfare services are relatively new, business has always been

*Sociologist, New York State Department of Mental Health.

supported by the Federal Government. Indeeed the whole so-called private sector, that is, farming, banking, industry, manufacturing, commerce, transportation, and communications have long had governmental support through many kinds of grants, rebates, depreciation allowances, and soil banks. Recently, the Federal Government has widened its support to include public utilities, such as, for example, absorbing 90 per cent of the cost of highways.

Local communities do not become alarmed because the Federal Government is paying for highway construction or supporting the soil bank; it is partly the novelty of its entering education, health and welfare that has created apprehension. More important than novelty, however, is probably fear that because health and welfare services are concerned with the relationships among individual people, federal support will mean governmental intrusion into interpersonal relationships. John Roche has pointed out, however, that for every person harrassed by such departments of the Federal Government as Income Tax or the F.B.I., many, many more are harrassed and intruded upon by local tax officials, local police and courts. Furthermore, local welfare departments are infinitely more intrusive than their federal counterpart.

Ultimately, citizens will accept the Federal Government's role in the health and welfare of the nation and think of it as complementing and supplementing, rather than supplanting local initiative.

FEDERAL, STATE AND LOCAL RELATIONSHIPS IN DEVELOPING MENTAL HEALTH PERSONNEL — 2. — Mr. Bernard Yabroff*

Mr. Yabroff, an economist, described the relationships among the activities of federal, state and local governments and particularly the sources of support for various training and research programs. He quoted extensively from two papers, "Guidelines for the Division of Adult and Vocational Research," and "Research Needs in Vocational-Technical Education for Program and Career Planning," both of which can be obtained from the NAMH national office. He pointed out that the Vocational-Education Act of 1963 was a turning point for federal government action in the fields of vocational and technical training, because it expressed a new national purpose — that all citizens should have an opportunity for the training that the country needed, as it becomes available. This 1963 Act removed earlier limitations on federal activity in the training area and since its pas-

*Director, Employment Opportunities Branch, Division of Adult Vocational Research, U. S. Office of Education.

sage, vocational education can be sponsored in any occupation up to a Bachelor's degree. Ten per cent of each year's allocations are marked for research and demonstration projects.

Mr. Yabroff pointed out that junior colleges and technical schools desperately need help from interested professionals and lay organizations in mental health in order to improve the quality of training and therefore the health and welfare of the target population. This speaker confirmed the theme put forward throughout the conference that there has to be a re-examination of job needs in the health field, followed by cooperative efforts to create needed training opportunities.

Mr. Yabroff went on to speak of the many research and demonstration questions that have to be dealt with, and gave a few examples of questions in urgent need of answering:

1. What is the best method for recruiting people into the training programs and ultimately the new jobs?
2. How can professional roles best be redefined so as to create new places for the new professionals?
3. How can the new jobs be made attractive enough to hold people in them?
4. How far can the physically and mentally handicapped, the poor and the uneducated be trained to fill the needed positions?
5. How effective are mental health careers programs?
6. Which of the methods used in the past can be demonstrated to be still effective now?

It is important that the new mental health worker be developed as a career and not just as a job. If this is to be done, certain courses of action are urgently needed. These include:

1. Talking with educationalists in vocational and technical schools as well as in community colleges,
2. exploring possibilities for new jobs for mental health institutions and organizations,
3. determining who among the many interested groups should be responsible for innovation and manpower development and use,
4. involving behavioral scientists in the problem.

Mr. Yabroff ended his talk by urging everyone interested in any kind of innovated action program to write to him at the following address: Bernard Yabroff, Director, Employment Opportunities Branch, Division of Adult Vocational Research, U. S. Office of Education, Washington, D. C. 20202.

Following Mr. Yabroff's presentation, Dr. Brown described the organizational structure as recently revised, of the National Institute of Mental Health. He suggested that the organizational chart was available from the NIMH Regional Offices, and that it would give insight into what branches of the Institute were interested in what activities. He urged the delegation to address their Regional Offices for advice and guidance about action programs. Addresses of regional offices can be obtained from NAMH National Office.

LOOKING AHEAD — THE TASK OF THE MENTAL HEALTH ASSOCIATION — Mr. Mike Gorman*

Mr. Gorman gave the wind-up address. He started by outlining progress that has already been made in the training area. In the National Institute of Mental Health's first budget, received from Congress 20 years ago, $2,000,000 was allocated for training while this fiscal year it is estimated that more than $90,000,000 will be available. Some of these funds are marked to go into other than traditional areas, furthermore. Some of the $11,000,000 that goes into physicians' training, for example, reaches out to thousands of general practitioners who attend short-term courses, and who were not part of the mental health spectrum in the past. Approximately $7,000,000 a year now goes to supporting training programs for non-professional workers in both state mental hospitals and schools for the mentally retarded. The annual hospital improvement grants are largely used for the acquisition of new personnel, including a number of new job classifications. The NIMH is also involved in supporting various manpower experiments. There are "educated housewives" in Washington, D. C.; teacher counselors are being trained at Peabody College, child care aides in Illinois, and "indigenous expeditors" are working with the disadvantaged in New York City.

Having listed these successes, Mr. Gorman pointed out that they were unfortunately only tokens of national interest with a relatively minute impact on the problems of mental health. In general, he said, the training of new kinds of technical manpower has always involved a lot of conversation followed by little or no action, mainly because of the pyramid of fierce jurisdictional resistance to any change in job classification. He pointed out that the psychiatrist is threatened by the clinical psychologist, the clinical psychologist by the social worker, the social worker by the nurse, the nurse by the licensed practical nurse, and the licensed practical nurse by the upgraded attendant, and so on, *ad infinitum*.

*Executive Director, National Committee Against Mental Illness.

Quoting Benjamin Pasamanick's 1953 comments, Mr. Gorman said, "I think that, if we were forced to supply all the care obviously required throughout the country, the psychiatrist would be so eager for all the help he could get, he would gladly hand over a good deal of the psychotherapy to non-medical therapists." He added that there are millions of people who lead empty, unoccupied lives and millions of people who need a helping hand, and many of the former are waiting to be recruited. Mr. Gorman said, however, that he was optimistic for the future, because of the successes of Project Head Start, the Vista program, the Foster Grandparents program and the Senior Service Corp., all of which are but the first responses to the call for service. He told the delegation that in the difficult manpower revolution they would have to be the catalysts, because it will never come about as a result of the enlightened efforts of a few psychiatrists, or the published thoughts of training committees. Only when, as in the case of Medicare, the nation gets the message that this is what a majority of the people want will great changes come.

On the whole, local and state Mental Health Associations have not done the job educationally, legislatively or financially, Mr. Gorman said. It is his deep-seated conviction that the movement is not tapping even ten per cent of the interest of the American people in the mentally ill. He did not believe the chapters and affiliates were doing their job of educating the people as to the enormity of the problem. They were not telling the public about the 800,000 people handled by the state hospitals each year, about the more than 3,000,000 people treated for mental illness each year, and the 2,000,000 who seek treatment and are denied it because of shortages of personnel and facilities. He described a recent visit to a large eastern city where he saw a state hospital, a county jail housing some 80 mental patients, a Child Guidance Clinic, a juvenile court clinic, a children's psychiatric treatment center, and a school for emotionally disturbed children. After seeing these places, he talked to county and state officials about changing their plans to put a new state hospital off in the country, urging them to use the money for a Community Mental Health Center. He said he was able to talk to these people as one who had a gut familiarity with the human anguishes resulting from the lack of any decent community mental health facilities. At none of these meetings, either in the facilities themselves, or with the officials, did he see anyone from the county Mental Health Association. He was told that they were too busy trying to raise $75,000 for an adult psychiatric clinic.

According to Mr. Gorman, this is exactly the way in which the Association fails. He described one midwestern field worker who had been in the same job for three years but had never visited the state hospital located in the very city in which he had his office. He suggested that if the movement claimed to be the major spokesman for the mentally ill, it had better get out and visit some of its clients.

In the field of money-raising the Mental Health Association has done no better. In comparison with other major voluntary health organizations the amount the NAMH collects from the American people is low. Last year the Cancer Society raised $45,000,000, the American Heart Association $30,000,000, the National T.B. Association $30,000,000, and a relative newcomer to the field the United Cerebral Palsey, more than $10,000,000, while the NAMH raised $7,000,000. The American Cancer Society is a good example of how an organization can grow. For years it raised very little money; it was dominated by doctors, and the national office had little control over the state societies. After World War II a few citizens on the National Board decided to shake up the structure. Their starting point was the direct provision of fund raising and program guidance to the various chapters. They assigned an experienced field worker to each state, and this close tie-in plus the activation of a very carefully planned women's field army, changed a loose federation into a powerful national organization. The NAMH has never achieved a national organization of any strength, according to Mr. Gorman.

Although a strong organizational structure and sound fund-raising are essential to getting the job done, the Association's basic need is to hammer out a program. An effective program is the end result of specific priorities in specific areas. The best example is still the patient in the mental hospital. In the 1940's, a band of newspaper men penetrated behind the walls of the state institutions and brought to the public a vivid picture of the plight of the mentally ill, but the Association did not follow it up with a program for change. Today, he continued, many newspapers are describing vividly the jailing of mental patients, but although there is an initial shock reaction from the public, there has been no follow-up, and the patients are still thrown in jail in many states. The same thing is true, he said, about big city receiving hospitals many of which have disgraceful psychiatric units. In recent months, newspapers have exposed the inhumane treatment of the mentally ill in receiving hospitals in Chicago, Detroit, New York and Miami, and yet the state and local Mental Health Associations have not capitalized upon this publicity to gain addi-

tional citizen support. Above all, the movement has not acted appropriately to implement the suggestions of the Joint Commission on Mental Illness and Health. It had very little to do with the drafting of the 1963 and 1965 Community Mental Health Legislation, the selection of the witnesses, or the final outcome in terms of congressional votes.

Finally, Mr. Gorman pointed out, a burning need right now is to persuade county government to develop Community Mental Health Centers. These jurisdictions do not have the tax resources of the other levels of government; at the same time, they are closest to the wrath of the taxpayer. He proposed that it is the job of the Association to wrestle with the county commissioners in their own areas, and on the whole they have not even come close to doing this tough job, because they cannot talk to county officials effectively. Mr. Gorman suspects that they do not have any real grasp of the problem they are discussing, nor do they represent a constituency, and the county officials know it. He suggested that all mental health workers, paid and volunteer, immerse themselves deeply in the basic problems of mental illness, and not let themelves be seduced into thinking that simple maneuvers like recruiting a few people from the so-called power structure of the local community will cause all obstacles to fall away. For the most part, he said, it isn't the names who do the job anyway, and such people frequently are associated with groups who are trying to hold taxes down. Furthermore, most newspapers and most county commissioners, and, indeed, politicians in general, seem to resent big names. In the end, the Association's biggest need is a broad citizen identification of the kind that eventually brought success to the National Foundation and the American Cancer Society. In Pennsylvania and Indiana, he pointed out, it was the large-scale citizen identification cultivated by competent directors and competent field workers that put a solid foundation under fund-raising and legislative activities.

Mr. Gorman concluded his talk by quoting from the late Dr. William Menninger, who, as he said, had working familiarity with all the big names in mental health, and who, nevertheless, came to the conclusion that, "Further progress in the difficult field of mental illness and mental health will come only when millions know enough, care enough, and are willing to work together hard enough to make it come."

SUMMARIES OF SEMINARS

In all seminars*, more questions were raised than answers provided, and considerable clarifications of the issues raised in the plenary sessions took place.

SEMINAR A

There was general agreement among the group that training programs should be developed for a wide range of health manpower needs rather than specifically for mental health. Specific skills should be developed later.

The following questions were raised:

1. Should Mental Health Associations be responsible for preparing a course of study for community colleges?
2. Should manpower training be done by Mental Health Associations?
3. Is the time right for manpower training?
4. Is the emphasis on manpower needs realistic?
5. Should Mental Health Associations determine where technical personnel are needed?

The participants generally agreed that the following strategies can be used effectively by Mental Health Associations:

1. Increased emphasis on Mental Health Careers programs in schools.
2. Identification of present and future manpower needs by arranging meetings of representatives from treatment facilities and from the various mental health professions.
3. Passage of appropriate legislation to aid in financing additional manpower.
4. Encouragement of appropriate courses in community college programs.
5. Developing professional advisory committees to determine if manpower is being suitably used.

*Seminar Faculty are listed in Appendix.

The group also discussed the need for a training program for the Board and for all staff executives. The following ingredients of a course in community organization were recommended:

1. Organizational structure
2. Community structure
3. Power structure
4. Program development
5. Administration and delegation
6. Legislative process
7. Current mental health issues

Sources of instruction recommended by the group were:

1. National and State mental health resources
2. College instructors
3. Professionals, including sociologists, social workers, political scientists, lobbyists.

SEMINAR B

The following questions were posed:

1. What is the demand we are trying to stimulate?
2. How do we go about stimulating it?
3. What kind of services do patients need?
4. What kind of skills are necessary?

It was generally agreed that the Mental Health Association should:

1. Help to determine manpower gaps,
2. Help to finance more personnel,
3. Provide community leadership to help a) develop public health approaches to mental health problems, b) create consumer demand for comprehensive services.
4. Evaluate the development of mental health technician programs.

It was generally agreed that the mental health technician can and should be utilized in all settings including the community.

SEMINAR C

There was general agreement among the group members that:

1. There is a specific need for the use of non-professional personnel in helping the mentally ill,

2. They have a contribution to make in the rehabilitation process,
3. They can be of assistance to and an adjunct to professional services,
4. There are resistances in the professional community,
5. The public needs to be educated,
6. The Mental Health Association has an important role to play in selling the use of non-professional manpower and its value to the mentally ill,
7. The Mental Health Association is the key agency in the community for stimulating and innovating this new program; it can bring together key persons and organizations in the community to evaluate and plan for more effective use of the non-professional.

It was unanimously agreed that non-professionals are not a substitute for professionals, but they can make the same valuable contribution that they have in related areas, such as dental nursing, etc.

The main area of confusion arose in relation to the role of the Mental Health Association in the training, orientation and recruitment of non-professional personnel. Some of the basic steps for action for a local chapter were highlighted briefly and it appeared that most participants of the seminar, but not all, have *some* idea of what they can do in their own communities.

SEMINAR D

The following questions were raised:

1. Is there a place for the non-professional in mental health work?
2. Do professionals want them?
3. Will professionals accept them?
4. Can professionals communicate with them?
5. What jobs can they do that volunteers cannot do and why?
6. Will there be conflict between volunteers and technical personnel?
7. Are Mental Health Associations willing to accept the new concept of technical non-professional personnel?
8. Should the Mental Health Associations become involved in recruitment and/or training?

It was generally agreed that:

1. There are signs that there is a place for and need of more workers in the mental health field.

2. Indigenous non-professionals can be used to "fill the gaps" and to supplement present services provided they were trained acceptably to both professionals and the public.
3. Professional skills should be utilized for planning in combination with the skills of the non-professional or indigenous worker.
4. Mental Health Associations can help professionals determine the possible areas of service by non-professional technicians.
5. Mental Health Associations should not become involved in actual training, but should educate the community to the need for new training programs at community colleges through close contact with state mental health authorities, local educators and civic leaders, and schools of social work and psychology.
6. Mental Health Associations can work with civil service boards in formulating job descriptions; they can use citizen pressure on governors' committees and legislators, as well as civil service commissions, to create more training opportunities, and to negotiate for satisfactory salaries.

Several questions were left unresolved:

1. Who will have to arrive at specific job descriptions?
2. Who will employ these new workers?
3. How do we work out details with civil service boards?

In its final session, the seminar members asked the question: "What will we do when we go home?" Suggested answers were:

1. Educate the local board,
2. Help determine needs in our own communities by establishing communication with professionals, educators, hospitals, guidance centers, social workers, youth opportunity services, guidance counselors, nursing homes, and other agencies.
3. Mental Health Associations should always be an information resource as to where the money is available for various community projects, and should always encourage others to use it.
4. Present job descriptions to community leaders, educators, professionals.
5. Promote the concept of technical personnel as an extension of already existing careers programs.
6. Work for acceptance, status and salaries for the new technical personnel and work to tap the labor market of mature housewives.

SEMINAR E

The following recommendations were submitted by Seminar E for consideration by the Mental Health Association Staff Council, the National Association for Mental Health, and the respective state divisions of the National Association for Mental Health. They reflect the discussions and decisions of the group.

1. That those participating in this seminar will interpret to their home communities the need for technical personnel in mental health programs, through such activities of the local chapters as fact-finding, community involvement, planning, and action programs.
2. State and national associations should contact various national professional organizations who will have a responsibility for interpreting to their members the effective use of technical personnel so that barriers to employment can be lessened. The state organizations should be sure to maintain close contact with those state groups responsible for determining civil service classification, licensure procedures, etc.
3. Training programs in community organization for the staffs of Mental Health Associations should be initiated at the earliest possible time.

APPENDIX

SCHEDULE OF EVENTS

Monday, July 11

11:00 a.m.	Registration opens.
3:00-4:15 p.m.	Informal small group discussions for all delegates, as assigned.
8:00-9:30 p.m.	Opening plenary session, Institute Chairman Max Silverstein, presiding. Address, "Why We're Here," Donald Kenefick, M.D.

Tuesday, July 12

9:00 am.-12:15 p.m.	Plenary session, Staff Council President W. Stanley Good, presiding. Address, "A Profile of Technical Personnel," Raymond Balester, Ph.D.; "New Frontiers in Training," Harold L. McPheeters, M.D.
12:30 p.m.	Lunch. Mr. Good, presiding. Remarks, Mr. Brian O'Connell, Executive Director, National Association for Mental Health.
1:30-3:30 p.m.	Seminars, as assigned.
9:00 p.m.	Optional slide presentation of a clinic-based Project Headstart activity.

Wednesday, July 13

9:00-10:30 a.m.	Plenary session, Mr. Raymond Glasscote, presiding. Address, "Cases of Effective Utilization of Technical Personnel in Mental Health Services," John Cumming, M.D.
11:00 a.m.-12 noon	Informal small group discussions, as assigned.
12:15 p.m.	Lunch, Mr. Glasscote, presiding. Remarks by Mrs. Winthrop Rockefeller.
1:30-3:15 p.m.	Seminars, as assigned.

Thursday, July 14

9:00 a.m.-12:15 p.m.	Plenary session, Mr. Harry Bryan, presiding. Address, "Barriers to Be Overcome," Bertram S. Brown, M.D., H. M. Forstenzer.
1:30-3:15 p.m.	Plenary session, Mr. Richard Hunter, presiding. Topic, "Federal, State, and Local Relationships in Developing Mental Health Personnel." Elaine Cumming, Ph.D., Bernard Yabroff, Bertram Brown, M.D
3:30-4:45 p.m.	Seminars, as assigned.

Friday, July 15

9:00-10:00 a.m.	Informal small group discussions, as assigned.
10:30 a.m.-12 noon	Plenary session, Mr. Max Silverstein, presiding. "Looking Ahead: The Task of the Mental Health Association," Mr. Mike Gorman.
12 noon	Institute adjourns.

FACULTY

Speakers, Plenary Sessions

BERNARD YABROFF, Director, Employment Opportunities Branch, Division of Adult Vocational Research, U. S. Office of Education

RAYMOND BALESTER, Ph.D., Chief, Experimental and Special Training Branch, National Institute of Mental Health

BERTRAM S. BROWN, M.D., Deputy Director, National Institute of Mental Health

MIKE GORMAN, Executive Director, National Committee Against Mental Illness

ELAINE CUMMING, Ph.D., Sociologist, New York State Department of Mental Hygiene

JOHN CUMMING, M.D., Deputy Commissioner, New York State Department of Mental Hygiene

H. M. FORSTENZER, Deputy Commissioner, New York State Department of Mental Hygiene

DONALD KENEFICK, M.D., Professional and Research Director, National Association for Mental Health

HAROLD L. MCPHEETERS, M.D., Associate Director for Mental Health Training and Research, Southern Regional Education Board

Seminar Leaders

ALAN LEVENSON, M.D., Director, Division of Mental Health Services Programs, National Institute of Mental Health (Group B)

PAUL WILSON, M.D., Chief, Information Processing Project, American Psychiatric Association (Group E)

Also, DRS. BALESTER (Group A) and CUMMING (Group D) and MR. FORSTENZER (Group C)

Mental Health Association
Resource Persons for Seminars

ROBERT M. SMUCKER, Erie County (Pennsylvania) Mental Health Association (Group A)

ARNOLD RABIN, Mental Health Association of Essex County, New Jersey (Group B)

S. STEVEN ROSNER, Massachusetts Association for Mental Health (Group C)

MARY HOLAND, Milwaukee County Mental Health Association (Group D)

MARTHA EDENS, California Association for Mental Health (Group E)
Conference Evaluator, DR. ELAINE CUMMING

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